

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-038871

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED OCT 19 1962

Primary Registration District No. 1002

Registrar's No.

5093

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		c. CITY OR TOWN <u>Kansas City</u>	
Length of stay in 1b <u>74 yrs</u>		Inside Limits <u>Yes</u> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>342 No Drury</u>		d. STREET ADDRESS (If outside, give location) <u>342 No Drury</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm <u>Yes</u> <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAYTON</u> Middle <u>MYERS</u> Last <u>MYERS</u>		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>K.P. Southern</u>	
11a. FATHER'S NAME <u>William H. Myers</u>		11b. BIRTHPLACE (City and state or country) <u>Kansas City, Mo.</u>	
13a. MOTHER'S MAIDEN NAME <u>Mary Jenkins</u>		14. NAME OF HUSBAND OR WIFE <u>Shady Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Shady Myers</u> Address <u>342 No Drury</u>	
18. CAUSE OF DEATH (Enter only one cause per line for terminal disease) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCULTION</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>5-10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9-58</u> a.m. <u>10-2-62</u> Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>KANSAS CITY, JACKSON MO.</u>		20f. CITY, TOWN, OR LOCATION <u>KANSAS CITY, JACKSON MO.</u>	
21. I attended the deceased from <u>9-58</u> to <u>10-2-62</u> and last saw her/him alive on <u>10-2-62</u> Death occurred at <u>10:30</u> A m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph M. Masucci M.D.</u>		22b. ADDRESS <u>Kansas City, Mo.</u>	
22c. DATE SIGNED <u>10-5-62</u>		23a. REMOVAL (Specify)	
23b. DATE <u>10-8-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>	
23d. LOCATION (City, town, or county) <u>Jackson MO</u>		(State)	
24. FUNERAL DIRECTOR <u>Shirley Turner Home</u>		25. DATE RECD. BY LOCAL REG. <u>10-7-62</u>	
26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

Joseph M. Masucci M.D.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.